

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN2355SNF</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/28/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>EVERGREEN AT CC HEALTH &amp; REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3050 N ORMSBY CARSON CITY, NV 89703</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>Surveyor: 23119 This Statement of Deficiencies was generated as the result of a complaint investigation conducted in your facility on 10/15/09 and finalized on 10/28/09, in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Complaint #NV00023077 was substantiated with deficiencies cited. (See Tag 230). Complaint #NV00023346 was substantiated with deficiencies cited. (See Tag 230). Complaint #NV00023226 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p>	Z 000		
Z230 SS=H	<p>NAC 449.74469 Standards of Care</p> <p>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the</p>	Z230		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Z230	<p>Continued From page 1</p> <p>comprehensive assessment conducted pursuant to NAC 449.74433 and the plan of care developed pursuant to NAC 449.74439.</p> <p>This Regulation is not met as evidenced by: Surveyor: 23119 Based on record review and interview the facility failed to ensure nursing staff removed narcotic medication patches prior to applying a new narcotic medication patch in accordance with the physician's order for 1 of 9 residents (Resident #2) and the facility failed to ensure nursing staff followed accepted professional standards of practice in the completion of the admission assessment for 3 of 9 residents (Residents #4, #5, and #8).</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility with diagnoses that included left hip arthrocentesis secondary to septic arthritis and hypertension. He had multiple medications for pain control and continued to complain of breakthrough pain.</p> <p>Resident #2's record review revealed that a Fentanyl 12.5 mcg patch was ordered on admission to the facility. On 9/11/09, the dosage of the Fentanyl patch was increased to 25 mcg. On 9/15/09, the Fentanyl patch was discontinued. On 10/1/09, the Fentanyl patch was increased to 50 mcg.</p> <p>In addition to the Fentanyl patch, Resident #2 had an order written on 9/12/09 for Roxicodone 20 mg every 6 hours as needed (PRN). The order was changed later that day to Roxicodone 20 mg every 4 hours PRN for 2 days, then resume Roxicodone 20 mg every 6 hours PRN. On</p>	Z230		

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Z230	<p>Continued From page 2</p> <p>9/16/09, an order was written for Roxicodone 20 mg every 4 hours PRN. On 9/23/09, an order was written to increase the OxyContin to 30 mg (from 20 mg) twice a day for chronic pain.</p> <p>Review of Resident #2's medication administration record revealed he received a Fentanyl patch 50 mcg applied on 10/1/09 and on 10/4/09. The documentation failed to revealed where the Fentanyl patches were placed, or if one was removed prior to the new patch being applied.</p> <p>Nursing documentation for Resident #2 revealed that, on 10/5/09 at 5:00 PM, the resident was "alert, a little sleepy today." A second entry for 5:00 PM revealed the resident was "still with altered level of consciousness" and he was unable to keep his eyes open. The nurse documented the resident was still complaining of pain with the Fentanyl patch, OxyContin at 8:00 AM, and the Oxycodone liquid that had been given at 1:00 PM.</p> <p>Resident #2 was transferred to the hospital on 10/5/09 for altered level of consciousness. Review of the record from the acute hospital revealed the emergency room physician documented the resident "had his Fentanyl patch doubled and subsequently has been falling asleep in mid sentence." The emergency room physician documented "we did remove all of his Fentanyl patches" and then the resident became more alert and responsive. Resident #2's primary admitting diagnosis to the acute hospital was "Altered level of consciousness, resolved."</p> <p>On 10/28/09, the transferring nurse from the unit where Resident #2 resided was interviewed. The nurse reported she removed a Fentanyl patch</p>	Z230			

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Z230	<p>Continued From page 3</p> <p>from Resident #2's chest while the Emergency Medical Technicians were at the desk.</p> <p>Residents #4, #5, and #8</p> <p>Record review revealed the admission nursing notes and assessments for Residents #4, #5, and #8 were documented prior to the residents arriving at the facility. Interview with the Staff Development Coordinator revealed the written admission assessments were actually the verbal report received from the transferring facility.</p> <p>According to the Lippincott Manual of Nursing Practice, Sixth Edition, the nursing assessment is defined as "systematic collection of data to determine the patient's health status and to identify any actual or potential health problems." The general principles for collecting the data in the assessment includes, "time spent early in the nurse-patient relationship gathering detailed information about what the patient knows, thinks, and feels about the problems will prevent time-consuming errors and misunderstandings later."</p> <p>Severity: 3 Scope: 2</p>	Z230		

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